STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 12/03/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/1/15 through 12/3/15. One complaint was investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 56 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents # 1 through 12) and two closed record reviews (Residents # 13 and 14).	F 000	Appomattox Health & Rehabilitation Center's Annual survey ending 12-03-2015 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of State and Federal regulations as outlined.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	To remain in compliance with all State and Federal regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nina H Smith	Administrator	12-10-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility staff failed for one of 14 residents in the survey sample (Resident # 2) to fully develop the resident's plan of care. Resident # 2's plan of care to address the identified problems of Activities of Daily Living and Communication was not fully developed.

The findings were:

Resident # 2's plan of care to address Activities of Daily Living and Communication was not fully developed.

Resident # 2 in the survey sample, a 68 year-old male, was admitted to the facility on 12/29/14, and most recently readmitted on 2/25/15 with diagnoses that included dementia, diabetes mellitus, bipolar disorder, hypertension, gastroesophageal reflux disease, vitamin B-12 deficiency, sepsis, hyperlipidemia, generalized muscle weakness, dysphagia, chronic kidney disease, anemia, hypokalemia, history of urinary tract infections, enlarged prostate, and convulsions. According to the most recent 5-Day Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/5/15, and the most recent Quarterly MDS with an ARD of 9/15/15, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 10 out of 15.

Review of Resident # 2's care plan, dated 9/15/15, revealed the following problem in the area of Activities of Daily Living (ADL), "The resident has an ADL self-care performance

1. Resident #2's care plan was corrected to address ADL's and Communication.

2. MDS coordinators and/or designee will review current residents that trigger "yes" for ADL's and communication in section V to ensure that these areas are addressed in the care plan with appropriate interventions. Care plans will be corrected immediately as indicated.

3. MDS coordinators and nursing leadership staff will be educated by corporate consultant regarding section V and developing care plans. Unit Managers or designees will review section V prior to care plan meetings to ensure items triggering "yes" are addressed in the care plan with appropriate interventions.
4. Process will be reviewed in QA committee for two quarters.

5. 12/31/15

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deficit." The goal for the problem was, "The resident will maintain current level of function through the review date."

The interventions for the stated problem included the following:
"AM ROUTINE: The resident's preferred dressing/grooming routine is (SPECIFY)
BATHING/SHOWERING: The resident is able to (SPECIFY)
BEDMOBILITY: The resident is able to (SPECIFY)
EATING: The resident is able to (SPECIFY)
PERSONAL HYGIENE: The resident is able to (SPECIFY)
TOILET USE: The resident is able to (SPECIFY)
TRANSFER: The resident is able to (SPECIFY)
DRESSING: The resident is able to (SPECIFY)
DRESSING: Make sure shoes are comfortable and not slippery. Resident prefers to wear (SPECIFY shoes)."

There was no explanation of the "SPECIFY" for each of the interventions.

Resident # 2's care plan also included the following problem for the area of Communication, "Resident at risk for impaired communication." The goals for the problem were, "The resident will maintain current level of communication function by through the review date. (sic) The resident will be able to make basic needs known on a daily basis through to review date."

The single intervention to the stated problem was, "Anticipate and meet needs." There were no additional interventions to address the resident's communication needs.

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F 279	Continued From page 3 The findings were discussed with the Administrator, Director of Nursing, and Corporate Nurse Consultant during a meeting at 2:30 p.m. on 12/2/15.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan (CCP) for one of 14 residents in the survey sample, Resident # 1. The facility staff failed to review and revise the CCP for Resident # 1 regarding nutritional	F 280	1. Resident #1 care plan was corrected to address significant weight loss and interventions. 2. Current residents were reviewed to ensure significant weight loss and interventions were included in care plan. Care plans were corrected immediately as indicated. 3. Director of Nursing and Dietary Manager were educated by RD regarding care plan accuracy to include resident significant weight loss and interventions.. Dietary Manager or Unit Manager and or designee will update care plans as applicable and will review/revise care plan as applicable when significant weight loss is identified. Unit managers or designees will review care plans weekly based on MDS assessment schedule to ensure accuracy of the care plan for significant weight loss. 4. Process will be reviewed in QA committee for two quarters. 5. 12/31/15	

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F 280	Continued From page 4	F 280		

interventions.

Findings include:

Resident # 1 was admitted to the facility on 04/19/15. Diagnoses for Resident # 1 included, but were not limited to: left frontal menigioma, muscle weakness, anxiety disorder, adjustment disorder with depressed mood, reflux and dysphagia.

The most current MDS (minimum data set) was a quarterly assessment dated 10/13/15. This MDS assessed the resident with a cognitive score of '13' indicating the resident was intact. The resident was also assessed as having non-prescribed weight loss.

During the clinical record review, it was documented through out that Resident # 1 was depressed and had a left frontal meningioma. The clinical record documented that the resident had a history of poor appetite and when questioned/interviewed about it, the resident would voice that she was happy with her weight.

Documentation in the clinical record evidenced that the facility had spoke with the family regarding the above information and the family voiced that the resident 'always thought she was fat' and had been 'teased' about her weight, and therefore would not eat a lot.

The clinical record documented that the resident was being seen by psychiatric services regularly and it was documented that the resident has had a personal history of poor appetite and/or being very particular about the food she eats.

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The resident's CCP was reviewed and documented: "...administer medications as ordered, diet as ordered, nectar thick liquids, invite to activities that promote intake, labs as ordered, provide and serve supplements as patient will accept...assist with feeding as she will accept...record and monitor weight..."

The resident's physician's orders were then reviewed and documented that Ensure plus and Regular diet (mechanical soft/nectar thick) was started on 11/17/15.

The resident's CCP's were then reviewed from admission and no other specific interventions were found related to alternative interventions to attempt to maintain or slow the resident's weight loss.

On 12/02/15 at approximately 2:15 p.m., the resident's RP (responsible party) was interviewed via telephone. The RP voiced that his mother thought she was fat and was teased when she was younger and was always particular about her weight. The RP stated, "You can't force her to eat."

The DON (director of nursing) was interviewed regarding concerns of the lack of interventions in place to attempt to maintain the resident's weight or to slow the progression of weight loss. The DON was asked for assistance in locating other interventions put in place for attempting to maintain the resident's weight on 12/02/15 at approximately 3:00 p.m.

On 12/03/15 at approximately 8:30 a.m., the DON presented a record of interventions. The DON was informed of the lack of interventions from

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F 280	Continued From page 6 04/20/15 through 06/09/15, in which time the resident had a 12.6 lb (pound) weight loss. The resident further lost an additional 14.5 lbs from June through November 5, 2015. At approximately 9:00 a.m., the DON, administrator, CDM (certified dietary manager) and the nurse consultant were made aware of concerns regarding the lack of interventions for the prevention or the maintaining of weight for Resident # 1. The CDM voiced that things had been done and often the resident will refuse. The staff were informed that information was not on the resident's CCP. The staff agreed that interventions should have been in place, even if the resident refused them to ensure that at attempt was being made to prevent weight loss or attempt to slow the progression of weight loss. No further information or documentation was presented to evidence that the facility initiated sufficient interventions in a timely manner, in an attempt to maintain the resident's weight, prevent weight loss, or at least slow the progression of weight loss prior to the exit conference on 12/03/15.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility failed to ensure safety interventions were in place for one of 14 Residents, Resident #8.

Resident #8 did not have fall mats in place.

Findings Include:

Resident #8 was admitted to the facility on 7/7/15 with diagnoses including, but not limited to: Muscle weakness, anxiety, reflux, vision loss, chronic kidney disease, and anemia.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/13/15. Resident #8 was assessed as being moderately cognitively impaired with a total cognitive score of 9 out of 15.

Resident #8's clinical record was reviewed on 12/1/15 and revealed a nursing note dated 8/7/15 that read in part "...CNA (certified nursing assistant) entering room, patient was found lying on floor beside the bed...Patient reported "I rolled out of bed onto the floor." ...Patient was assessed by (name of nurse)...reporting a "red" area to patient's right posterior upper arm. No further injuries noted...Recommendations: ...Fall mats with low bed to be initiated..."

On 12/1/15 at 2:00 p.m. Resident #8 was observed lying in bed with only one fall mat on the left side of the bed, there was no other fall mat in the room during the time of the observation.

1. Resident #8 fall mats are currently in place.

2. Current residents with fall mats will be reviewed to ensure mats are in place per plan of care. Any issues will be immediately corrected at the time of observation.

3. Current facility staff will be educated regarding fall mat placement. Residents will be visualized by nursing administration daily 5x weekly to identify any fall mats not in place. Any issues will be corrected immediately at the time of identification.

4. Process will be reviewed in QA committee for two quarters.

5. 12/31/15

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F 323	Continued From page 8 At this time CNA #1 (nursing assistant assigned to resident #8) was interviewed and was asked about only one fall mat being in place. CNA #1 verbalized, Resident #8 was transferred on the left side of the bed, not the right side. This surveyor explained to CNA #1, according to documentation, Resident #8 rolled out of bed and fall mats were initiated. This surveyor asked CNA #1 if there was an information sheet such as a Kardex or care plan to inform staff how to care for each resident. CNA #1 verbalized the facility uses Kardex's for the CNA's. Resident #8's current Kardex was then reviewed and read (under the heading of "Safety")"...Low bed with fall mats." Resident #8's care plan was reviewed and read in part "Focus" area "Resident had actual fall" dated 8/7/15. "Interventions, ...fall mats times 2..." Resident #8's "Post Fall Assessment" dated 8/7/15, documented "Device change, low bed with mats." On 12/2/15 at 1:00 p.m. the above finding was brought to the attention of the administrator and director of nursing (DON). The DON verbalized understanding. No other information regarding the above finding was presented prior to exit conference on 12/3/15.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		

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The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a medication error rate of less than 5 percent during a medication pass/pour observation. There were 3 errors out of 32 opportunities. The facility medication error rate was 9.37% and affected one of 12 residents in the survey sample, Resident # 10.

Resident # 10 was administered one hydrocortisone 5 mg (milligram) tablet, instead of three (15 mg) as ordered by the physician; the resident was also administered one Colace/Senna (50 mg/8.6 mg), instead one sennoside 8.6 mg tablet and was additionally administered fluticasone propionate suspension (Flonase) 50 mcg (micrograms) one spray per nostril, when the physician's order was for two sprays per nostril.

Findings include:

During a medication pass and pour observation on 12/02/15 at approximately 8:00 a.m., LPN (Licensed Practical Nurse) # 1 prepared medications for Resident # 10.

LPN # 1 retrieved Resident's 10's medications from the medication cart, which included, but were not limited to: Hydrocortisone (5 mg) pill card, a stock bottle of colace/senna (50 mg/8.6 mg) tablets, and a bottle of Flonase (50

1. Resident #10 is currently receiving medications as ordered by the MD.

2. Current residents receiving Hydrocortisone, Flonase, and Senna will be reviewed to ensure doses are being administered as ordered by MD. Corrections will be made immediately as indicated.

3. Nursing staff will be educated regarding procedures for accurate medication administration and will be observed by SDC or designee during a medication pass for validation. SDC or designee will observe one medication pass biweekly to ensure medication doses are being given as ordered by MD. Any issues will be addressed immediately at the time of identification.

4. Process will be reviewed in QA committee for two quarters.

5. 12-31-15

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mcg/spray). The LPN dispensed one hydrocortisone tablet and one colace/senna (50mg/8.6mg) tablet, with other medications. The LPN dispensed 12 pills into the plastic medication cup.

After the LPN had prepared all medications for administration, the LPN and this surveyor counted the pills to be administered by mouth. The number of pills in the plastic medication dispensing cup were counted twice and confirmed to be 12. The LPN then added applesauce to the medication dispensing cup and entered the resident's room, along with the Flonase nasal spray.

LPN # 1 administered the medications in the dispensing cup and then proceeded to administer the Flonase 50 mcg. The LPN administered one spray per nostril.

A medication reconciliation was completed for Resident # 10, on 12/02/15 at approximately 9:00 a.m.

Resident # 10's current physician's orders documented: "...Hydrocortisone tablet 5 mg Give 3 tablet by mouth one a day...Sennosides tablet 8.6 mg Give 1 tablet by mouth two times a day...Fluticasone Propionate suspension 50 mcg 2 spray in each nostril one time a day..."

At approximately 9:30 a.m., LPN # 1 was interviewed regarding the above. LPN # 1 was asked to pull up the computerized MAR (medication administration record) and pull the three above mentioned medications from the cart for viewing.

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F 332	Continued From page 11 The LPN looked at the hydrocortisone medication card and voiced that she did not realize that the resident was suppose to get three of the pills to make 15 mg. The LPN then took the stock bottle of colace/senna (50 mg/8.6 mg) and looked at it and voiced that she had 'always went by that' pointing to the senna 8.6 mg on the bottle. The LPN was asked if that was the same medication, that was actually ordered for the resident. The LPN voiced, no. The LPN then looked at the MAR and the bottle of Flonase and voiced, 'she's suppose to get two sprays, we even have it highlighted.' On 12/02/15 at approximately 1:00 p.m., the DON (director of nursing) and the nurse consultant were made aware of the above. The administrator, DON and nurse consultant were again made aware of the above in a meeting with the survey team on 12/03/15 at approximately 8:30 a.m. No further information or documentation was presented prior to the exit conference on 10/22/15 at 7:15 p.m.	F 332		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 425		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure medication was available for administration for one of 14 residents in the survey sample, Resident # 5.

The facility staff failed to ensure the medication clonazepam 0.5 mg (milligrams) was available for administration for Resident # 5.

Findings include:

Resident # 5 was admitted to the facility on 07/14/15, with the most current readmission on 08/13/15. Diagnoses for Resident # 5 included, but were not limited to: ovarian cancer with metastasis, asthma, arthritis, depression, and sleep apnea.

The most current MDS (minimum data set) was a quarterly review dated 11/17/15. The resident

1. Resident #5 is currently receiving clonazepam per schedule as ordered.

2. Current residents receiving antianxiety medications, medications will be reviewed to ensure doses are being administered as ordered by MD. Any issues will be addressed immediately at the time of identification.

3. Nursing staff will be educated regarding procedures for acquiring medications from the pharmacy and medication administration to include notification of the pharmacy and MD as indicated. Unit Managers and/or designees will review the missing administrations report daily 5x weekly to identify any missed administrations. Any issues will be corrected at the time of identification.

4. Process will be reviewed in QA committee for two quarters.

5. 12/31/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 12/03/2015

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was assessed with a cognitive score of "12", indicating the resident had moderate impairment in daily decision making skills. The resident was also assessed as having pain, 'almost constant', with a pain score of '8'.

During the resident's clinical record review, a nursing note dated 11/30/15 and timed 8:05 p.m. documented: "Clonazepam tablet dispersible 0.25 mg Give 2 tablet by mouth at bedtime for anxiety related to chronic back pain Give two tablets (0.5mg) by mouth every night (bedtime) Awaiting on Rx (prescription) from pharmacy will administer upon arrival per MD (medical doctor)..."

The resident's MAR (medication administration records) were then reviewed and documented for 11/30/15 at 9:00 p.m.: "...initials 5..." The code number "5" documented 'Hold/See progress notes'.

The physician's orders were then reviewed and documented: "...Clonazepam tablet 0.25 mg Give 2 tablet by mouth at bedtime for anxiety related to chronic back pain Give 2 tablets (0.5 mg) by mouth at bedtime (start date: 10/15/15)..." The physician's orders also documented and order to: "...May hold meds until arrival from pharmacy (start date: 08/13/15)..."

The DON (director of nursing) was interviewed on 12/02/15 at approximately 1:00 p.m., regarding the above. The DON voiced that the order to hold meds should have been discontinued and was not intended to use for the Clonazepam. The DON voiced that order was for the resident on the last admission, which was 08/13/15. No other physician's orders were located to hold

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medications, specifically the Clonazepam on 11/30/15.

The DON was asked what the expectation was for medications unavailable. The DON voiced that if the medication is not available, the nurse should first call the pharmacy, if unable to get then call the back up pharmacy. The DON voiced that Clonazepam was not a medication that was in their stat box.

The DON was asked for a policy on medication availability.

The facility's policy was presented and reviewed. The policy titled, "Medication Shortages/Unavailable Medications" documented: "...Facility staff should immediately initiate action to obtain the medications from the pharmacy...call pharmacy to determine the status of order...nurse should place the order or reorder for the next scheduled delivery. If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency medication supply to administer the dose. If the medication is not available in the Emergency Medication supply, facility staff should notify pharmacy and arrange emergency delivery...after normal pharmacy hours...call pharmacy's emergency answering service...to manage plan of action...emergency delivery; or use of an emergency (back-up) third party pharmacy...if emergency delivery is unavailable ...contact the attending physician to obtain orders or directions..."

No further information or documentation was presented prior to the exit conference on

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